PATIENT DENTAL RECORD

PATIENT No:_____ INSURANCE TYPE:_____

WE have the interest and desire to listen, really listen, to what you are saying. Please don't hesitate to ask about anything you don't understand. You are dealing with members of a team whose ***primary job*** is to serve you... ***WE*** promise that you will never leave feeling that no one cares.

In order to begin treatment, the following information is necessary. ***PLEASE COMPLETE FULLY AND PRINT LEGIBLY.***
All information, of course, will be held in strict confidence.

PATIENT HISTORY INFORMATION

PATIENT'S NAME_____ HOME PHONE_____

SOC. SEC. No._____ BIRTHDAY_____ AGE_____ SEX_____ MARITAL STATUS_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

E-MAIL ADDRESS_____ Cell Phone _____

PATIENT'S EMPLOYER_____ WORK PHONE_____

SPOUSE'S NAME_____ SPOUSE'S EMPLOYER_____ WORK PHONE_____

PERSON TO NOTIFY IN CASE OF EMERGENCY_____ PHONE_____

STUDENT: ☐ FULL TIME ☐ PART TIME SCHOOL_____ CITY_____

RESPONSIBLE PARTY'S INFORMATION - *Fill out if different from Patient History Information*

PERSON RESPONSIBLE FOR ACCOUNT_____
LAST FIRST MIDDLE

RELATIONSHIP TO PATIENT_____ HOME PHONE_____ WORK PHONE_____

MAILING ADDRESS_____ CITY_____ ZIP_____

SOC. SEC. No._____ DRIVER LICENSE No._____

EMPLOYER_____ OCCUPATION_____

EMPLOYER'S ADDRESS_____ CITY_____ ZIP_____

HAVE YOU OR ANY MEMBER OF YOUR FAMILY BEEN A PATIENT BEFORE? ☐ NO ☐ YES, IF YES PLEASE FILL OUT

NAME_____ WHEN?_____

DENTAL INSURANCE ☐ YES ☐ NO

INSURED'S NAME_____

SS#_____ BIRTH DATE_____

EMPLOYER_____

INS. CO. or PLAN_____

GRP.or POLICY#_____ LOCAL_____

DATE EMPLOYED_____

SECONDARY DENTAL INSURANCE ☐ YES ☐ NO

INSURED'S NAME_____

SS#_____ BIRTH DATE_____

EMPLOYER_____

INS. CO. or PLAN_____

GRP. or POLICY#_____ LOCAL_____

DATE EMPLOYED_____

HOW DID YOU HEAR ABOUT THIS OFFICE? ☐ FORMER PATIENT (NAME)_____

☐ TELEPHONE BOOK ☐ BUILDING SIGN ☐ EMPLOYER ☐ ADVERTISEMENT (Specify) ☐ OTHER (Specify)_____

_____

WHY ARE YOU HERE TODAY?_____
CHECKUP, TOOTHACHE, CONSULTATION, ETC.

IS ANY CURRENT DENTAL PROBLEM THE RESULT OF AN ACCIDENT ☐ YES ☐ NO IF YES WHEN?_____

CONSENT

I authorize my dental office to use, disclose, and release personal health, medical, and dental information only to other dentists, physicians, insurance carriers, and healthcare finance companies for the purpose of treatment, treatment options, determination of eligibility, payment, healthcare operations, utilization review, and financial audits.

I am NOT authorizing the use of my personal information to be sold to any entity for the purpose of marketing.

I hereby authorize my insurance carrier to pay directly to WESTLA Dental the dental benefits otherwise payable to me. In the event that my dental insurance carrier should not pay the full amount estimated for any services rendered, I agree to be financially responsible for the remaining balance. I understand that the amount quoted to me as my portion for dental services is an estimate only and may vary according to the limitations and policies of my particular insurance company. I also understand that any overdue balance on my account will be subject to a billing fee.

_____ _____
PATIENT DATE

_____ _____
RESPONSIBLE PARTY DATE

PATIENT HEALTH HISTORY

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care.
Please answer each question. Circle **Yes** or **No**

MEDICAL HISTORY

1. Are you in good health? ..... Yes No
2. Date of last physical examination _____
3. Physician: Name_____ Address_____ Phone Number ( )_____
4. Are you now under the care of a physician? ..... Yes No
   If so, what is the condition being treated? _____
5. Have you ever had any serious illness or operation? ..... Yes No
   If so, what illness or operation? _____
6. Have you ever been hospitalized? ..... Yes No
   If so, what was the problem? _____
7. Are you taking any medicine ☐ Yes ☐ No, or any recreational drugs (marijuana, cocaine, etc.)? ..... Yes No
   If so, what? _____ What dosage? _____
8. Have you ever been pre-medicated with antibiotics for your dental treatment? ..... Yes No
9. Are you sensitive or allergic to any drugs? ☐ Penicillin; ☐ Tetracycline; ☐ Sulfa Drugs; ☐ Aspirin; ☐ Codeine; Yes No
   ☐ Other If Other, what drugs? _____
10. Do you have or have you had any of the following: (Please check √ known conditions) ..... Yes No

Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
☐ ☐ Anemia	☐ ☐ Cold Sores	☐ ☐ Sinus Trouble	☐ ☐ Blood Transfusions	☐ ☐ Pain in Jaw Joints	☐ ☐ X-Ray or Cobalt
☐ ☐ Herpes	☐ ☐ Hemophilia	☐ ☐ Blood Disease	☐ ☐ Joint Replacement	☐ ☐ Respiratory Disease	☐ ☐ Fainting Spells or Seizures
☐ ☐ Stroke	☐ ☐ Rheumatism	☐ ☐ Drug Addiction	☐ ☐ Nervous Disorders	☐ ☐ Sickle Cell Disease	☐ ☐ Chemotherapy (Cancer, Leukemia)
☐ ☐ Ulcers	☐ ☐ Heart Murmur	☐ ☐ Kidney Disease	☐ ☐ Tumors or Growths	☐ ☐ Tuberculosis (T.B.)	☐ ☐ Radiation Treatment of any kind
☐ ☐ Diabetes	☐ ☐ Bruise Easily	☐ ☐ Stomach Ulcers	☐ ☐ Allergies or Hives	☐ ☐ Epilepsy or Seizures	☐ ☐ Hepatitis or Jaundice
☐ ☐ Glaucoma	☐ ☐ Head Injuries	☐ ☐ Angina Pectoris	☐ ☐ Cortisone Medicine	☐ ☐ Artificial Prosthesis	☐ ☐ Venereal Disease (Syphilis, Gonorrhea)
☐ ☐ Arthritis	☐ ☐ Heart Failure	☐ ☐ Mental Disorder	☐ ☐ Excessive Bleeding	☐ ☐ Psychiatric Treatment	☐ ☐ Acquired Immune Deficiency Syndrome (AIDS)
☐ ☐ Emphysema	☐ ☐ Liver Disease	☐ ☐ Rheumatic Fever	☐ ☐ Asthma	☐ ☐ Congenital Heart Lesions	☐ ☐ TMJ (Temporomandibular joint)
☐ ☐ Hay Fever	☐ ☐ Scarlet Fever	☐ ☐ Thyroid Disease	☐ ☐ High Blood Pressure	☐ ☐ Difficulty in Swallowing	☐ ☐ Hearing Impaired
☐ ☐ Tonsillitis	☐ ☐ Mitral Valve Prolapse	☐ ☐ Cerebral Palsy	☐ ☐ HIV Positive	☐ ☐ Heart Ailments or Attack	☐ ☐ Latex or Metal Allergy ☐ Other_____

11. Do you wear a cardiac pacemaker, or have you had heart surgery ..... Yes No
12. Do you have any disease, condition or problem not listed that you think I should know about? ..... Yes No
    If so, what? _____
13. Do you smoke, or use any tobacco products? If yes, how much?_____ per day ..... Yes No
14. (Women) is there a possibility you may be pregnant? ..... Yes No
15. (Women) Do you have any problems associated with you menstrual period? ..... Yes No
16. (Women) Do you take birth control pills? ..... Yes No
17. Have you taken Fenfluramine and Dexfenfluramine (Fen-Phen), Dexfenfluramine (Redux) or Fenfluramine (Pondimin)? ..... Yes No

DENTAL HISTORY

1. Previous Dentist _____ City _____
2. Have you been having any specific problem? ..... Yes No
   Explain: _____
3. Does dental treatment make you nervous? ..... Yes No
   If so, √: ☐ Slightly ☐ Moderately ☐ Severely
4. Do you have, or have you had any of the following: (Please check √ known conditions) ..... Yes No
   ☐ Bad Breath ☐ Loosening of Teeth ☐ Headaches ☐ Bleeding Gums
   ☐ Sensitive Teeth ☐ Jaws "Pop" or "Lock" ☐ Sinus Trouble
5. Have you ever had any of the following? ..... Yes No
   ☐ Injury ☐ Oral Surgery ☐ Orthodontics ☐ Periodontics
   Explain: _____
6. Are you a participant in any sport? ..... Yes No
   Explain: _____
7. Have you ever had any unfavorable reaction from a local anesthetic? ..... Yes No
8. Have you had any serious trouble associated with any previous dental treatment? ..... Yes No
9. How long since your last dental x-rays?_____
10. How long since you last dental treatment? _____
11. Would you desire to be pre-sedated? ☐ Nitrous Oxide ☐ Drugs ☐ or _____ Yes No
12. It is our intention to make your visit as comfortable as possible. Please comment on how we may further this for you.

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will,without fail, inform the doctor at my next appointment.

PATIENT, PARENT/GUARDIAN Signature: _____ Date: _____

DENTIST Signature: _____ Date: _____

Year 2 REVIEWED BY
Changes in Health _____
Patient
Date_____ Signature _____ (DDS)_____
YEAR 2

Year 3
Changes in Health _____
Patient
Date_____ Signature _____ (DDS)_____
YEAR 3

Health Questionnaire MUST be updated every year!

DO NOT WRITE IN THIS SPACE

	Current Year	Year 2	Year 3
Date	____	____	____
BP	__/__	__/__	__/__
Pulse	____	____	____
Temp	____	____	____
By	____	____	____

WEST LA DENTAL

Please let us know on how best to confirm your future appointments and recalls:

NAME:_____

TELEPHONE:_____

E-MAIL:_____

TEXT MESSAGE:_____

POSTCARD:_____

_____